BEHAVIORAL HEALTH

Provider	Project Unique ID	Project Option	Subcategory	Cat 3 Measure	CN #s Addressed	Description	Grouping for QPI Measure as captured by HHSC - Individuals or encounters	QPI Metric Description	QPI Target per HHSC: DY3	QPI Target per HHSC: DY4	QPI Target per HHSC: DY5	CUMULATIVE DY5 total for the QPI measure	Total Incentive Payment DY2-5 Category 1 and 2
Methodist Willowbrook Hospital	140713201.2.1	2.17.1	Care Transition	• IT 9.4e Emergency Department visits for Behavioral Health/Substance Abuse	3	Recruit qualified people to intervene and guide care, educate staff, identify community partners, re-engineer our discharge planning process to ensure patients transition into the ambulatory care setting successfully, setting up care coordination protocols to make sure we identify patient accurately who need our assistance and following our system's CQI efforts of plan, do, check and act to ensure we're achieving our expected outcomes for this target population.	Individuals	Increase in number of patients receiving Follow-Up After Hospitalization for Mental Illness within 7 and 30 days	380	684	722	1786	$ 4,939,422
St. Joseph Medical Center	181706601.2.1	2.17.1	Care Transition	• IT 3.15 Risk Adjusted Behavioral Health/Substance Abuse 30-day Readmission Rate	3	• Partial Hospitalization Program • Take voluntary patients and patients must agree to the program rules. • All patients are seen by a psychiatrist, psychiatric residents and a RN. They attend four "core" groups per day ran by a licensed therapist. • The program runs from the hours of 9:00 to 3:00 and a small breakfast, lunch and snacks are provided.	Individuals	Improvement in percentage of "High Risk" patients with customized care plans before discharge	196	261	333	790	$ 8,205,536
The Methodist Hospital	137949705.2.1	2.17.1	Care Transition	• IT 9.4e Emergency Department visits for Behavioral Health/Substance Abuse	3	• Recruit qualified people to intervene and guide care, educate staff, identify community partners, re-engineer our discharge planning process to ensure patients transition into the ambulatory care setting successfully, setting up care coordination protocols to make sure we identify patient accurately who need our assistance and following our system's CQI efforts of plan, do, check and act to ensure we're achieving our expected outcomes for this target population.	Individuals	Increase in number of patients receiving Follow-Up After Hospitalization for Mental	2330	4194	4384	10908	$ 13,443,521
MHMRA-Harris County	113180703.2.3	2.17.1	Care Transition	• IT 3.15 Risk Adjusted Behavioral Health/Substance Abuse 30-day Readmission Rate • IT 11.25 Daily Living Activities	3, 6, 9	• Redesign the transition from HCPC hospitalization to MHMRA outpatient aftercare • Hire two (2) licensed mental health professionals to engage patients pre-discharge from HCPC and assist with successfully linking them to community mental health treatment.	Individuals	Increase the use of warm handoffs (a clinician to clinician real time live communication) for adult inpatients being discharged to the community	1500	1575	1575	4650	$ 2,212,418
MHMRA-Harris County	113180703.1.11	1.13.1	Care Transition	• IT 11.26c Adult Needs and Strength Assessment (ANSA)	2, 5, 12, 13, 14	• Expand the Crisis Residential Unit (CRU). This 24-bed unit is specifically designed as a step-down from hospitalization. • Reduce the number of bed days required for acute psychiatric hospitalization • Reduce hospitalization re-admission rates • Increase tenure in the community and utilization of outpatient treatment alternatives	Individuals	Patient admissions to CRU program	0	321	321	642	$ 19,441,205
Fort Bend County Clinical Health Services	296760601.1.1	1.13.1	Crisis Stabilization	• IT 9.4.e Emergency Department visits for Behavioral Health/Substance Abuse	3	• Develop a crisis system that better identifies people with behavioral health needs, responds to those needs and links persons with their most appropriate level of care. • Assess and enhancee 911 dispatch system to identify and respond to behavioral health crises • Develop a specialized crisis intervention team (CIT) within Fort Bend County Sheriff's Office • Implement cross systems training and linkages to appropriate services and supports.	Individuals	Decrease in preventable admissions and readmissions into Criminal Justice System	0	1600	1600	3200	$ 8,840,021
Memorial Hermann Hospital	137805107.1.2	1.13.1	Crisis Stabilization	• IT 9.4e Emergency Department (ED) visits for Behavioral Health	1, 6, 8, 9	• Provide rapid access to initial psychiatric treatment and outpatient services. • Identify consumers with behavioral health needs that can be addressed and avoid unnecessary use of emergency departments, hospitalization or incarceration	Individuals	Increase in utilization of appropriate crisis alternatives.	0	3100	5400	8500	$ 16,559,854
Texana Center	081522701.2.1	2.13.1	Crisis Stabilization	• IT 11.26b Aberrant Behavior Checklist (ABC)	?	• Provide crisis stabilization intervention for the dually diagnosed population to prevent unnecessary use of services in State Supported Living Centers, emergency rooms, state mental hospitals and county jails.	Individuals	Number of targeted individuals enrolled / served in the project	150	185	225	560	$ 5,574,005
Texana Center	081522701.1.2	1.13.1	Crisis Stabilization	• IT 1.18 Follow-Up After Hospitalization for Mental Illness	3	• Develop an 8 bed 48-hour extended observation unit and a 14 bed crisis residential unit where individuals in crisis may go to be assessed and stabilized by providing crisis intervention services. • Provide a clinically appropriate setting and less costly alternative to hospital inpatient stays, emergency room visits, and jail.	Individuals	Increase in number of patients	600	624	648	1872	$ 11,976,097
MHMRA-Harris County	113180703.1.8	1.13.1	Crisis Stabilization	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication • IT 11.25 Daily Living Activities	2, 5, 12, 14	• Develop interim Care Clinic, which is designed to provide initial evaluation and treatment in a single visit. • Include extended evening hours and availability seven days a week.	Individuals	Patients served at ICC program	1350	1100	3450	5900	$ 12,561,090

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MHMRA-Harris County	113180703.2.4	2.13.1	Crisis Stabilization	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication • IT 11.25 Daily Living Activities	3, 6, 9	• Expand the Chronic Consumer Stabilization Initiative (CCSI), an interagency collaboration with the Houston Police Department (HPD). • Provide intensive case management and work directly with individuals, family members, health providers, and/or staff at living facilities. • Provide family and community education about mental illness, outreach and engagement, intensive case management, Mental Health First Aide (an evidence-based mental health awareness program for community members), navigation to address physical health, housing and other social needs, crisis intervention and advocacy typically for several months, longer than other crisis diversion programs.	Individuals	Number of targeted individuals enrolled / served in the project	40	50	60	150	$ 1,179,949
MHMRA-Harris County	113180703.2.5	2.13.1	Crisis Stabilization	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication • IT 11.26c Adult Needs and Strength Assessment (ANSA)	2, 5, 12, 14	• Expand the current Mobile Crisis Outreach Team (MCOT), which provides mobile crisis outreach and follow-up to adults and children who are unable or unwilling to access traditional psychiatric services. • Respond to the consumers' needs with two trained MCOT staff when a consumer initiates an MCOT intervention • Meet consumers in a variety of settings including in the consumer's community, home, or school • Provide assessment, intervention, education, and linkage to other services to address identified needs.	Individuals	Number of targeted individuals enrolled / served in the project	200	450	720	1370	$ 11,939,410
Bayshore Medical Center	020817501.1.2	1.7.1	Crisis Stabilization	• IT 3.15 Risk Adjusted Behavioral Health/Substance Abuse 30-day Readmission Rate	3, 6, 8, 10, 12, 18	• Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region • Expand existing telemedicine program to include a 24/7 tele-psychiatry program in its Bayshore Emergency Department (ED) • Implement telemedicine capabilities in the EDs at its other local hospitals. • Identify the necessary technology to establish the program, reach out to behavioral health providers to participate, train the ED staff at each hospital to effectively use the new capabilities • Implement protocols for obtaining telepsychiatry consults and referrals to and from Bayshore.	Encounters	The number of telemedicine visits	2310	2911	3038	8259	$ 14,178,531
MHMRA-Harris County	113180703.2.7	2.13.1	Crisis Stabilization	• IT 11.26c Adult Needs and Strength Assessment (ANSA)	3, 6, 9, 10	• Provide an crises intervention response team • Expand three additional teams of the Crisis Intervention Response Team (CIRT), which is a program that partners law enforcement officers who are certified in crisis intervention training with licensed master-level clinicians to respond to law enforcement calls.	Encounters	Number of targeted individuals enrolled / served in the project.	300	600	900	1800	$ 7,215,482
MHMRA-Harris County	113180703.1.5	1.12.2	Expand Behavioral Health	• IT 11.26.e.i Patient Health Questionnaire 9 (PHQ-9) • IT 11.26c Adult Needs and Strength Assessment (ANSA)	3, 6, 9	• Expand outpatient services for adults with severe psychiatric conditions (Southwest) • Place one new treatment team which can serve about 500 consumers on an outpatient basis in the Southwest region of the city.	Individuals	Number of patients who utilize community behavioral healthcare services.	250	500	500	1250	$ 13,168,403
MHMRA-Harris County	113180703.1.6	1.12.2	Expand Behavioral Health	• IT 11.26.e.i Patient Health Questionnaire 9 (PHQ-9) • IT 11.26c Adult Needs and Strength Assessment (ANSA)	3, 6, 9	• Expand outpatient services for adults with severe psychiatric conditions (Southeast) • Place one new treatment team which can serve about 500 consumers on an outpatient basis in the Southeast region of the city.	Individuals	Number of patients who utilize community behavioral healthcare services.	250	500	500	1250	$ 13,168,403
MHMRA-Harris County	113180703.1.1	1.12.2	Expand Behavioral Health	• IT 11.26.e.i Patient Health Questionnaire 9 (PHQ-9) • IT 11.26c Adult Needs and Strength Assessment (ANSA)	3, 6, 9	• Place one new treatment team which can serve about 500 consumers on an outpatient basis in the Northwest region of the city.	Individuals	Number of patients who utilize community behavioral healthcare services.	250	500	500	1250	
MHMRA-Harris County	113180703.1.3	1.9.2	Expand Behavioral Health	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication • IT 11.26b Aberrant Behavior Checklist	3, 6, 9, 18	Develop wrap-around and in-home services for high risk consumers with Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) and their families to avoid utilization of intensive, costlier services.	Encounters	Documentation of increased number of visits.	3400	8500	9350	21250	$ 6,690,813

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MHMRA-Harris County	113180703.1.4	1.12.2	Expand Behavioral Health	• IT 11.26.e.i Patient Health Questionnaire 9 (PHQ-9) • IT 11.26c Adult Needs and Strength Assessment (ANSA)	3, 6, 9	• Expand outpatient services for adults with severe psychiatric conditions (Northeast) • Place one new treatment team which can serve about 500 consumers on an outpatient basis in the Northeast region of the city.	Individuals	Number of patients who utilize community behavioral healthcare services.	250	500	500	750	$ 13,168,403
Harris Health System	133355104.1.9	1.12.2	Expand Behavioral Health	• IT IT-11.26.e.i Patient Health Questionnaire 9 (PHQ-9)	3, 18	• Implement and expand pediatric and adolescent behavioral health services across nine facilities within the system. • Expand psychiatry by adding 3.7 FTE's of psychiatry and 7.6 FTE's of behavioral therapy.	Individuals	Percent utilization of community behavioral healthcare services.	1837	3122	4371	9330	$ 18,446,459
Memorial Hermann Northwest Hospital	20834001.1.3	1.12.2	Expand Behavioral Health	• IT 9.4e Emergency Department (ED) visits for Behavioral Health	3	• Expand home health service to include psychiatric services. • Include specialized training and certifications for nurses and the addition of social work services to link clients to additional community care programs. • Provide support of those patients with mental health issues • Better manage their care in the home and community • Reduce the number of visits to emergency departments for psychiatric care that could be managed in the home/community environment.	Encounters	Percent utilization of community behavioral healthcare services.	0	880	920	1800	$ 16,752,576
MHMRA-Harris County	113180703.1.7	1.12.2	Expand Behavioral Health	• IT 11.26.e.i Patient Health Questionnaire 9 (PHQ-9) • IT 11.26c Adult Needs and Strength Assessment (ANSA)	3, 6, 9	• Expand outpatient services for adults with severe psychiatric conditions (Region determined according to need) • Place one new treatment team which can serve about 500 consumers on an outpatient basis in specified region of the city.	Individuals	Number of patients who utilize community behavioral healthcare services.	250	500	500	1250	$ 13,168,403
MHMRA-Harris County	113180703.1.9	1.12.2	Expand Behavioral Health	• IT 9.1 Mental health admissions and readmissions to criminal justice settings such as jails or prison • IT 11.25 Daily Living	3, 6, 9	• Clubhouse Expansion - The intervention is the ICCD Clubhouse Model, which is a day treatment program for psychosocial rehabilitation of adults diagnosed with a serious and persistent, chronically disabling mental health problem.	Individuals	Number of patients who utilize community behavioral healthcare services	20	80	209	309	$ 6,586,745
MHMRA-Harris County	113180703.1.10	1.9.2	Expand Behavioral Health	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication • IT 11.16 Assesment for Substance Abuse Problems of Psychiatric Patients • IT 11.19 Assesment of Psychiatric Patients • IT 11.21 Assesment of Major Depressive	3, 6, 9, 10	• Establish behavioral healthcare clinic within the Lighthouse facility in order to provide mental health treatment capacity for persons with visual impairment • Include identification of behavioral health needs, interventions, case management, patient and family education and coordination with primary care. • Develop services to address the specialized needs of persons with visual impairment with a mental health disorder to support wellness and independent functioning in the community.	Individuals	Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2).	25	125	150	300	$ 2,616,615
Texana Center	081522701.1.3	1.9.2	Expand Behavioral Health	• IT 10.3d Battelle Development Inventory-2 (BDI-2)	2	• Implement a system of early identification and delivery of therapeutic services that blends the best aspects of private therapy and a natural environment based model • Include social work and/or monitoring by a child development specialist to support parental involvement and supplement the number of clinical hours recommended.	Encounters	Documentation of increased number of visits.	3600	3000	4500	11100	$ 4,220,390
Texana Center	081522701.1.1	1.12.2	Expand Behavioral Health	• IT 10.4.a Developmental Profile 3 (DP-3) • IT 10.4b Vineland Adaptive Behavior Scales, 2nd Edition (VABS II)	3	• Enhance Service Availability of appropriate levels of behavioral health care (i.e., applied behavior analysis and speech-language pathology for children diagnosed with autism) • Develop and implement evidence-based interventions of ABA and SLP in an additional location for children with a diagnosis of ASD. Interventions include assessment, treatment development, and intervention overseen by Board Certified Behavior Analyst, BCBA, and Speech Language Pathologists, SLP, as well as training care givers using ABA.	Individuals	Number of individuals receiving community behavioral healthcare services.	24	36	40	100	$ 9,105,687
MHMRA-Harris County	113180703.2.9	2.17.2	Expand Inpatient Behavioral Health	• IT 1.18 Follow Up After Hospitalization for Mental Illness • IT 3.14 Behavioral Health/Substance Abuse 30-day Readmission Rate	2, 5, 12, 14	• Expand and further develop the Inpatient Consultation and Liaison (C&L) team that provides consultation and services to patients suspected of Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) referred by attending physicians at the Harris County Psychiatric Center (HCPC) • Provide similar services to other inpatient settings in Harris County.	Individuals	Increase in High Risk Patients who are discharged with customized care plans.	40	140	140	320	$ 7,093,560

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Spindletop Center	096166602.2.2	2.14.1	Health Education	• IT 6.2.a Client Satisfaction Questionnaire 8 (CSQ-8)	1, 16, 17	• Develop a web-based portal where secure client-focused health information can be accessed by our mental health clients and will implement a phone tree system to send reminders and alerts to clients via phone and/or email. • Train our mental health clients in the use of this technology and the information provided to help them manage their behavioral and physical health care. • Use a focus group of selected clients, peer specialists, and staff to determine the health and other information to include on the portal and the communication devices that would be most useful to clients based on their level of need. These devices could include the phones that CMS provides for Medicaid clients and computers at kiosks in Spindletop's outpatient clinics, supportive housing units, and our peer-run support center. • May also test lending Wi-Fi enabled tablets or smartphones to select clients.	Individuals	Percentage of participants successfully managing their health	0	10	12	22	$ 186,649
MHMRA-Harris County	113180703.2.1	2.15.1	Integrated Care	• IT 1.7 High blood pressure • IT 1.10 Diabetes Care: HbA1c poor control (>9.0%)	3, 6, 9, 10	• Design, implement, and evaluate a care management program that integrates primary and behavioral health care services.	Individuals	Number of Individuals receiving both physical and behavioral health care at the established locations.	800	1000	1400	3200	$ 19,142,532
MHMRA-Harris County	113180703.2.2	2.13.1	Integrated Care	• IT 11.8 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment • IT 11.26c Adult Needs and Strength	3, 6, 9	• Integrate substance abuse treatment services and embed into existing MHMRA mental health treatment services.	Individuals	Number of targeted individuals enrolled / served in the project	300	800	800	1900	$ 18,419,173
City of Houston Department of Health and Human Services	093774008.2.8	2.19.2	Integrated Care	• IT 10.1.B.iii RAND Short Form 36[1] (SF-36) Health Survery • IT 11.26.e.i Patient Health Questionnaire 9 (PHQ-9)	?	• Serve 200 individuals who are chronically homeless and offer comprehensive service integration intervention. • Implement its comprehensive five step intervention for the homeless involving 1) permanent housing supportive model 2) program service linkages 3) physical and behavioral health needs 4) financial support 5) other services.	Individuals	Number of targeted individuals enrolled / served in the project.	150	180	200	530	$ 10,911,392
Gulf Bend	135254407.2.1	2.15.1	Integrated Care	• IT 1.18 Follow-Up After Hospitalization for Mental Illness	1, 3, 5, 6, 7, 8, 9, 10, 11, 18, 20, 23	• Develop and implement a Person-Centered Behavioral Health Medical Home in Port Lavaca, TX. • Target at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments or jails. • Offer the following services in the same location: o Behavioral Health Services o Primary care services o Health behavior education and training programs o Long and short term care for those with mental illness and co-occurring chronic disease o Case Management services to help patient navigate the	Individuals	Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise	125	150	200	475	$ 3,550,000
Harris Health System	133355104.1.10	1.12.4	Integrated Care	• IT IT-11.26.e.i Patient Health Questionnaire 9 (PHQ-9)	2, 3	• Enhance service availability of appropriate levels of behavioral health care to adults by expanding mental health services in the ambulatory care setting. • Add therapists and psychiatrists (13.4 Psychiatry and Behavioral Health FTEs) to existing Harris Health System health centers across Harris County.	Individuals	Number of unique individuals receiving BH services through expansion of services	1200	3200	4,800	9200	$ 21,641,667
MHMRA-Harris County	113180703.2.8	2.13.1	Integrated Care	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication • IT 10.2.a Supports Intensity Scale (SIS)	3, 18, 20	• Provide community based interventions for individuals to prevent them from cycling through multiple systems, by providing community-based, wrap-around services that help stabilize behavioral problems in the natural home • Link the patient and family to other supports, such as a medical home, transition services to help individuals establish a stable living environment, peer support, employment, specialized therapies, respite, personal assistance, and linkage to short or long term residential options.	Individuals	Number of targeted individuals enrolled / served in the project	80	92	100	272	$ 6,679,087

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Spindletop Center	096166602.2.1	2.15.2	Integrated Care	• IT 1.10 Diabetes Care: HbA1c poor control (>9.0%)	1, 2, 5, 10	• Co-locate primary care clinics in its existing buildings to facilitate coordination of healthcare visits and communication of information among healthcare providers. • Purchase a mobile clinic and equip to provide physical and behavioral health services for our clients in locations other than existing Spindletop clinics. • Supplement the benefits of integrating primary care with behavioral health services by implementing Individualized Self Health Action Plan for Empowerment ("In SHAPE"), a wellness program for individuals with mental illness.	Individuals	Individuals receiving both physical and behavioral health care at the established locations	10	15	20	45	$ 1,178,561
St. Joseph Medical Center	181706601.2.2	2.15.1	Integrated Care	• IT 9.4e Emergency Department visits for Behavioral Health/ Substance Abuse	3	• Create Medical Psychiatry Unit that would have a strong emphasis on the medical issues while also focusing on the mental health needs of the clients at the same time. • Train the medical psychiatric nursing and support team in trauma-informed care models and the interface between medical and psychiatric problems.	Individuals	Individuals receiving both physical and behavioral health care at the established locations/Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise	281	530	600	1411	$ 12,623,903
Texas Children's Hospital	139135109.1.16	1.9.2	Integrated Care	• IT 11.26.e.v Edinburg Postpartum Depression Scale	2, 15, 18	• Create access resources which will allow us to diagnosis women quicker and enhance their quality of life. • Educate and training obstetricians and pediatricians to improve screening in post-partum depression, to understand the challenges of psychiatric medications during pregnancy and breastfeeding, and to understand the mental health needs of menopausal women.	Encounters	Documentation of increased number of visits.	50	910	980	1940	$ 2,196,500
The University of Texas Health Science Center - Houston	111810101.2.7	2.15.1	Integrated Care	IT 1.9 Depression management: Depression Remission at Twelve Months	3, 12, 18	• Design, implement and evaluate a project that will integrate primary and behavioral healthcare services within UT Physicians' clinics to achieve a close collaboration in a partly integrated system of care (Level IV). • Place a behavioral health provider in the primary care setting to provide patients with behavioral health services at their usual source of health care. • Facilitate care coordination between primary and behavioral healthcare.	Individuals	Individuals receiving both physical and behavioral health care at the established locations	500	1000	1,250	2750	$ 13,134,966
The University of Texas Health Science Center - Houston	111810101.2.8	2.15.1	Integrated Care	• IT 10.1.a.v Pediatric Quality of Life Inventory (PedsQL) • IT 11.15 Depression Screening by 18 years of age	3, 18	• Integrate primary and behavioral healthcare services for children and adolescents within UT Physicians' clinics to achieve a close collaboration in a partly integrated system of care (Level IV). • Place a pediatric behavioral health provider in the primary care setting to children and adolescents with behavioral health services at their usual source of health care. • Facilitate care coordination between primary and behavioral healthcare.	Individuals	Individuals receiving both physical and behavioral health care at the established locations	500	1000	1250	2750	$ 16,418,710
Fort Bend County Clinical Health Services	296760601.2.2	2.13.1	Juvenile Detention Diversion	• IT 9.1 Mental health admissions and readmissions to criminal justice settings such as jails or prisons	3	• Design, implement and evaluate a program that diverts youth with complex behavioral health needs such as serious mental illness or a combination of mental illness and intellectual developmental disabilities, substance abuse and physical health issues from initial or further involvement with juvenile. • Individualize services • Include assessment, multidisciplinary treatment planning, crisis stabilization services, family supports, respite, specialized therapies (trauma focused interventions, cognitive behavioral interventions), medication management, case management and wraparound supports.	Individuals	Number of targeted individuals enrolled / served in the project	10	20	25	55	$ 661,274
City of Houston Department of Health and Human Services	093774008.1.4	1.13.1	Sobering Center	• IT 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	?	• Conduct monitoring, screening, assessment, service plan development and linking participants to care (if willing) for a maximum of individuals (N=8000/year) and a minimum of N=6000/year, who frequently display a range of mental and physical symptoms that indicate alcohol or other substance abuse in DY4-5.	Encounters	Number of encounters provided	6000	6000	6000	18000	$ 7,710,357

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Texana Center	081522701.2.100	2.15.1	Integrated Care	• IT 1.7 Controlling High blood pressure	1, 11, 18, 20	This project will hire a primary care physician and other appropriate staff to provide primary care services to the Medicaid and uninsured population currently being served by Texana Center for their mental illness. By providing both services in the same building, by the same performing provider, a warm hand off can be made the same day as the visit to the behavioral healthcare provider. The interventions will include screenings, treatment, medication services, education services including disease management and nutrition, exercise and wellness.	Individuals	Enroll and serve individuals with targeted complex needs	150	180	225	555	$ 3,400,000
The University of Texas Health Science Center - Houston	111810101.1.100	1.12.2		• IT 11.26.d Children and Adolescent Needs and Strengths Assessment (CANS-MH) • IT 11.15 Depression Screening by 18 years of age • IT 11.22 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	3	The program will expand capacity and access to Trauma Informed care (TIC) mental health services for children and adolescents and will conduct mental health assessments, and provide a number of interventions with a particular focus on addressing trauma in underserved children. The TIC primary intervention offered will include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based practice and general counseling (such as Cognitive Behavioral Therapy). In order to expand access and capacity, these interventions will be anchored in DePelchin satellite clinics in proximity to several areas of socioeconomic need and will then progressively expand to community settings such as schools and primary care clinics. Developing a telemedicine capability for children in Foster Care.	Individuals	Increase in number of individuals utilizing community behavioral healthcare services	N/A	1600	3200	4800	$ 11,336,068
MHMRA-Harris County	113180703.1.101	1.11.2	Case Management	• IT I.18 Follow-Up After Hospitalization for Mental Illness	3, 8, 9, 10, 20	MHMRA will be providing telephonic and text based follow-up case management and online emotional support to patients	Encounters	Number of encounters provided by telemental services	700	1263	1700	3663	$ 392,608
MHMRA-Harris County	113180703.1.100	1.13.1	Integrated Care	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication •IT 11.25 Daily Living Activities (DLA-20)	2, 3, 6, 8, 20	MHMRA will expand its current co-occurring disorders program from a 30 bed to an ultimate 60 bed capacity. In this program, MHMRA partners with licensed chemical dependency residential treatment providers to offer up to 90 days of integrated co-occurring disorders care. Current research indicates this is a best practice and requires a wide range of collaboration between substance-use and mental health arenas. Integrated treatment providers have a broad knowledge base and are equipped to treat individuals with co-occurring disorders.	Individuals	Number of individuals served using appropriate crisis alternatives	N/A	72	101	173	$ 6,895,367
MHMRA-Harris County	113180703.2.100	2.13.1	Crisis Stabilization	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication •IT 11.25 Daily Living Activities (DLA-20)	3, 6, 9	MHMRA plans to expand the Chronic Consumer Stabilization Initiative (CCSI), an interagency collaboration with the Houston Police Department (HPD). Staff members provide intensive case management and work directly with individuals, family members, health providers, and/or staff at living facilities. MHMRA provides family and community education about mental illness, outreach and engagement, intensive case management, Mental Health First Aid (an evidence-based mental health awareness program for community members), navigation to address physical health, housing and other social needs, crisis intervention and advocacy typically for several months, which is longer than other crisis diversion programs.	Individuals	Number of targeted individuals enrolled/served in the project	10	20	30	60	$ 752,999
MHMRA-Harris County	113180703.2.101	2.13.1	Crisis Stabilization	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication •IT 11.25 Daily Living Activities (DLA-20)	3, 6, 9	MHMRA proposes to expand the current Mobile Crisis Outreach Team (MCOT), which provides mobile crisis outreach and follow-up to adults and children who are unable or unwilling to access traditional psychiatric services.When a consumer initiates an MCOT intervention, two trained MCOT staff responds to the consumers' needs, meeting them in a variety of settings including in the consumer's community, home, or school and provide assessment, intervention, education, and linkage to other services to address identified needs.	Individuals	Number of targeted individuals enrolled/served in the project	200	250	270	720	$ 11,208,050
MHMRA-Harris County	113180703.2.102	2.13.1	Case Managemen	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication •IT 11.25 Daily Living Activities (DLA-20)	3, 6, 9, 10	The Critical Time Intervention Program (CTI) is a nine-month case management model emphasizing developing community linkages and enhancing treatment engagement for mentally ill individuals undergoing transition.	Individuals	Number of targeted individuals enrolled/served in the project	42	42	45	129	$ 2,711,436
MHMRA-Harris County	113180703.2.103	2.13.1	Expand Behaviora	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication •IT 11.25 Daily Living Activities (DLA-20)	3, 6, 8, 9, 18, 20	Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Preventative mental health care for foster youth.	Individuals	Number of targeted individuals enrolled/served in the project	84	52	53	189	$ 3,547,932

BEHAVIORAL HEALTH

Provider	Project Unique ID	Project Option	Subcategory	Cat 3 Measure	CN #s Addressed	Description	Grouping for QPI Measure as captured by HHSC - Individuals or encounters	QPI Metric Description	QPI Target per HHSC: DY3	QPI Target per HHSC: DY4	QPI Target per HHSC: DY5	CUMULATIVE DY5 total for the QPI measure	Total Incentive Payment DY2-5 Category 1 and 2
MHMRA-Harris County	113180703.2.104	2.13.1	Data Sharing	• IT 8.23 Children and Adolescents' Access to Primary Care Practitioners (CAP) • IT 11.25 Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • IT 8.24 Adolescent Well-Care Visits (AWC)	5, 6, 9, 12, 14	Implementation of an electronic system that will enable juvenile service providers to work together in a coordinated approach guided by mutually identified goals, shared access to information, and a collaborative treatment and service plan.	Individuals	Number of targeted individuals enrolled/served in the project	750	1000	1250	3000	$ 4,041,000
MHMRA-Harris County	113180703.2.105	2.13.1	Detoxification	• IT 6.1.b.ii CG-CAHPS 12-month: Provider Communication • IT 11.8 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	2, 6, 7, 9, 14, 15, 18	The proposed project will increase local treatment capacity by adding 8 new residential detoxification beds, with 4 of those beds available to women accompanied by their children. Average length of stay will range from 5-14 days depending on type of substance used and duration of use, severity of co-occurring mental health issues, and pregnancy/health status.	Individuals	Number of targeted individuals enrolled/served in the project	150	150	150	450	$ 9,863,100
OakBend Medical Center	127303903.2.101	2.9.1	Expand Behavioral Health	• IT 3.15 Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	8, 9, 10	Provide rapid access to initial psychiatric treatment and outpatient services for patients with behavioral health needs who frequently seek treatment in the Emergency Department	Individuals	Increased number of unique patients served by Navigator program	0	100	150	250	$ 3,533,333
Memorial Medical Center	137909111.1.100	1.12.2	Expand Behavioral Health	• IT 6.2.c Health Center Patient Satisfaction Survey • IT 11.26.e.i Patient Health Questionnaire 9 (PHQ-9)	1, 2, 3, 6, 18	This project is supportive of our Region's goal to expand access to behavioral health care services in an outpatient setting and provide patients with the care they need, when they need it.	Encounters	Number of encounters provided in community based behavioral healthcare setting	200	450	500	1150	$ 1,199,000
Fort Bend County Clinical Health Services	296760601.2.100	2.15.1	SBIRT	• IT 11.8 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	3, 7, 12, 18	The proposed project will enhance the current health care delivery system by adding a Screening, Brief Intervention and Referral to Treatment model (SBIRT) in the AccessHealth FQHC clinic in Richmond, Texas. This evidence-based model includes: Screening: Universal screening for quickly assessing use and severity of alcohol, illicit drugs, and prescription drug abuse.	Individuals	Number of Individuals receiving both physical and behavioral health care at the established locations.	150	225	300	675	$ 462,000
Fort Bend County Clinical Health Services	296760601.2.101	2.13.1	Integrated Care	• IT 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	2	Fort Bend County proposes to develop a continuum of care that is based on evidence based practices for target group (persons with severe mental illness and / or mental illness and physical health conditions) identified as high risk for recidivism due to homeless/ lack of stable housing, prior history of non compliance, lack of access to services, complex trauma, lack of family supports and /or lack of integrated care to address complex needs.	Individuals	Number of targeted individuals enrolled/served in the project	0	20	30	50	$ 918,000
								Total Incentive Payment Amount for Behavioral Health					**$ 457,168,662**